

cular, as an earnest for the future of still larger and more valuable contributions to the literature of Surgery.

The entire number of cases of gunshot injury reported is 20,930; and the tables set forth respectively, the Seat and Character of the Wounds, with the result; the Treatment; the Character of the Missiles; the Amputations performed; the Excisions performed; the Extraction of Balls; the results of thirty-five cases of Trephining; the Ligature of Bloodvessels; and the Miscellaneous Operations.

The preparation of tables such as these demands an extraordinary amount of zeal, industry, and caution, in order to make them correct. The value we set upon them must depend in a very great measure upon our estimate of the character of the person by whom they have been compiled, and it is needless to say that no one can be more deserving of the confidence of the profession than the compiler of these tables—Dr. Brinton.

W. F. A.

ART. XXI.—*Transactions of the Obstetrical Society of London*, Vol. IV. For the Year 1862; with a List of Officers, Fellows, &c. 8vo. pp. 338. London, 1863.

THE present volume of the Transactions of the Obstetrical Society equals fully, in the interest and practical value of its contents, either of its predecessors. Of several of the papers comprised in it, very full abstracts have already been given in our quarterly summaries for the past year.

The annual address of the President, Dr. W. Tyler Smith, contains no suggestions directly applicable to the condition of the profession in this country—none, at least, which could be successfully carried into practice without a radical change in the political institutions under which we live; we shall pass it by, therefore, and proceed at once to a brief notice of such of the papers contained in the volume as have not already been noticed in preceding numbers of the *Journal*.

Dr. G. Hewett, of London, relates a case of *spina bifida* (pp. 5, 6), occurring in a child delivered by one of the midwives of the British Lying-in Hospital, October, 1861. The labour was easy, and occurred at full term. The mother stated that she had had a fall two months previously. The child, a female, presented no defect save that the spinous processes, which were readily recognizable by the finger as far as the junction of the lumbar and sacral regions, were, with the entire bony arch over the middle of the sacrum, defective. At this spot was situated a tumour, smooth, soft, easily compressible, measuring one and a half inches across, and raised above the surrounding surface three-quarters of an inch. It evidently contained a fluid, which oozed *guttatim* from a minute aperture in the skin covering it. Two days after birth Dr. H. found the greater part of the skin covering the tumour of a deep red colour—one portion, however, was of a yellowish hue, and if not already gangrenous, threatening to become so. The tumour was felt under the skin to be surrounded by a slightly elevated bony margin. Its fluid contents could be made in great part to pass inwards by pressure. The general condition of the child was good, the movement of its lower extremities unimpaired, its body warm; it sucked vigorously and slept well. Pads were applied on each side the tumour to guard it from external friction or pressure, more active treatment being deferred until the skin covering it should assume a more healthy aspect.

For the first six days the patient went on well; it then, however, became weaker as regarded its power of sucking, convulsions set in, and twelve days after birth death took place. The case when first seen seemed to be a favourable one for an attempt at cure. It was hoped that by carefully guarding the skin against friction, by the use of collodium, and slight pressure kept up by bandages, retraction of the sac might have been produced.

Another case of *spina bifida* is reported by Dr. D. Richards, of Brighton; of which the history is given in a subsequent part of the volume (pp. 191–94).

It will be more convenient, however, to notice it in connection with the foregoing. In this second case the defect in the spine became associated with hydrocephalus.

The patient, a female, was the first-born of a strong, healthy, well-formed mother. At the lower part of the dorsal region spina bifida existed, with an absence of three entire spinous processes. The integuments also were wanting, so that there existed an opening instead of the usual tumour filled with a fluid—the spinal column being apparently exposed to about one inch in depth. Angular curvation of the spine at this part was present; the palate was cleft, and there was talipes varus of both feet; the head at birth was healthy and of normal size.

Immediately after birth, the aperture in the back began to close by granulations. At the end of twenty-eight days the left leg descended from the shoulder to its natural position; two weeks subsequently the right leg partially descended. The cavity in the spine had now become entirely closed up with granulations level with the surrounding skin. The granulating surface in wet weather appeared wet and inclined to throw out a thin discharge, while in fine weather the surface looked dry and as if covered with skin.

As the cavity closed, the infant's head was observed to enlarge. Thirty-one days after birth its circumference was 18½ inches; two weeks subsequently it was 18½ inches; two weeks later, 19 inches; at the end of another two weeks, 19½ inches; two weeks later, 19½ inches; while at the end of the next three weeks it had a circumference of 23 inches. At this size, very nearly, it remained for over ten weeks, when a diminution was observed. A slight anasarca, which had existed for a short time, began at the same time also to diminish, and by the end of five days had altogether subsided. The size of the head was now reduced to that which it presented at birth, and the aperture in the spine was completely healed. Six days later, five months and seven days subsequent to birth, the child died from exhaustion. No examination of the body was allowed.

The second paper in these Transactions is *A Report on Mr. Spencer Wells' Case of Exfoliation of the Female Bladder*, by Dr. Harley. (pp. 13–17.)

The specimen sent to Dr. H. for examination was passed, it is stated, by the urethra six weeks after a severe instrumental labour. From the time of delivery up to the period when the specimen was voided the patient was confined to her bed, with symptoms of acute cystitis, associated with nephritis. The urine, examined about three weeks after delivery, was albuminous, and contained blood corpuscles, pus cells, chylous matter, and renal tube casts. At the same time the fresh urine was very much loaded with carbonate of ammonia, and was intensely alkaline, even at the moment when passed. This condition of the urine would alone, in the absence of all other evidence, be sufficient to justify the diagnosis of cystic and renal disease. An examination per vaginam the day before the specimen was expelled detected nothing in the vagina; shreds of a sloughy-looking tissue were, however, observed to project from the orifice of the urethra. A hard swelling had been felt in the anterior wall of the vagina, supposed by one practitioner to be an abscess, by another, a foreign substance in the bladder. After the discharge of the substance the patient's health rapidly improved. She is married, and there is no apparent cause for suspecting her of deceit.

The specimen is an animal membrane, in the form of a bag, perfect on all sides save one, in which are several irregular rents. Exteriously its colour is white, and even to the naked eye distinctly muscular. The muscular fibres, upon close inspection, were found to be of the involuntary kind, and distributed in the same interlacing manner as in the urinary bladder. Interiorly the bag is of a dark colour, and covered throughout with a gritty deposit, the removal of which brought into view a smooth, mucous surface. The gritty matter upon analysis proved to consist of crystalline phosphates and urates. Upon the muscular coat of the specimen were found, under the microscope, a number of tube casts and granular cells. But, as Dr. H. remarks, as the specimen had been in water for two days, these may have been accidentally floated out from the interior of the organ. On minute inspection of what seems to be its outer surface, there is seen an irregular patch, of about two inches by one in extent, of smooth tissue, bearing a close resemblance to serous membrane, being, probably, a por-

tion of peritoneum. The distilled water in which the specimen was steeped for two days, deposited a quantity of phosphate of lime, and of urate of soda and ammonia. The supernatant fluid had a milky appearance, resembling lime water, which it retained even after filtration. Neither ureters nor their orifices were to be detected in the specimen. It was impossible to ascertain whether the specimen is an entire organ, or only the portion of an organ, in consequence of the torn condition of its lower part.

From the foregoing data Mr. H. is led to the conclusion that the specimen is a portion of a urinary bladder, which at one part is, probably, of its entire thickness—as it appears to possess at this part, an internal mucous, a middle muscular, and an external serous coat.

Taking it for granted that the specimen in question was to be viewed as a true pathological specimen, it appeared to Dr. H. that we must accept as true one or other of the following theories:—

“1st. That a woman voided, by the natural passage, nearly her whole bladder. Or, 2d. That the entire mucous membrane, with nearly the whole of the muscular coat, had become, by some means or other, dissected from the neighbouring tissues, and exfoliated in the form of a perfect cast.”

Dr. Tanner referred to a case, the exfoliated membrane obtained from which is preserved in the collection of the Royal College of Surgeons, which is adapted to throw light upon the foregoing—bearing out the correctness of the second of the theories proposed by Dr. Harley.

Dr. J. G. Swayne related a curious case of *discoloration of the skin during pregnancy* (pp. 18, 19). The subject of the case was a blond, with rather florid complexion, brown hair, and blue eyes, twenty-six years of age. Had always enjoyed good health. After her fourth labour, Dr. S. observed a very general discoloration of both forearms and hands, much more marked, however, upon the dorsal than on the palmar aspect. It was most intense at the wrist, where the skin was of a rich, yellowish-brown hue, as dark as that of the mulatto. From the wrist it became gradually paler, until at the elbow, the skin regained its normal colour, but so gradually as to render it impossible to indicate any line of separation between this and the morbid tint. At the wrist, however, the line of demarcation was very distinct, the colour being deeper and extending further on the dorsal than on the palmar surface. On the backs of the hands and fingers it assumed the form of isolated patches, with irregular crescentic outlines, and occupied chiefly the knuckles. The patches coalesced on the forearms, giving to them a more uniform dark tint; still the patches, having irregular concave edges, could be traced, inclosing, here and there, circular patches of white skin. A similar discoloration of the skin had been present in each of the lady's preceding pregnancies. The dark colour first appeared towards the end of the third month, and gradually increased until labour set in. After delivery it soon began to diminish in intensity, and at the end of three months had disappeared. The lady's mother had borne two children, and in each of her pregnancies both the arms and neck presented the same form of discoloration.

Henry Raynes, Esq., of Gringley, reports a case of *difficult labour from the locking of the heads of twins* (pp. 19, 20), analogous to the one described in the last volume of the *Transactions* by Dr. Pollock.

Labour had considerably advanced before Mr. R. was called in. The breech presenting was promptly converted into a footling case. The further progress was impeded by the locking together of the heads of two children, which were reversed so as to allow of the inferior margins of the lower jaws being placed in juxtaposition. Mr. R. excised the head of the child whose body was born, and which was ascertained to be dead. The head of the other child being in advance of the first, retained its place until after the birth of the latter, the detached head of which retiring above the brim, permitted the progress of the second child, which was born without manual assistance, and expired soon after birth. The detached head of the first child was now extracted by a little manipulation, the fingers of the operator being inserted in its mouth.

Dr. Pollock's case, already referred to, and one by Mr. Eaton, noticed in *Braithwaite's Retrospect*, vol. xiv., are the only other cases similar to that of Mr. Raynes, which are known to be on record.

A case of *retained menses* of two years' duration, from *atresia vaginae: puncture of rectum followed by recovery*, is related by I. Baker Brown (pp. 21, 27).

Where there is a deficiency or entire absence of the vagina in a young female, unattended with arrest of development of the uterine organs, pain and other evidences of an effort to menstruate may recur monthly, and pass off without the patient suffering any serious inconvenience. There is a liability, however, of a constant accumulation of the menstrual fluid, giving rise, ultimately, to constant painful distension of the uterus, for the relief of which surgical interference will be demanded. Such cases are, confessedly, of rare occurrence; in the majority of them the attempt made to afford relief by puncture, or otherwise, has had an untoward result. The general opinion of surgeons is that, when the uterus is punctured through the rectum death almost invariably occurs; how far this opinion is borne out by facts it is impossible to say. Dupuytren has opened the closed womb through the vagina in several cases. Inflammation of the uterus of so severe a character ensued that he finally abandoned the operation, allowing the patient to die quietly and slowly, rather than to accelerate her death by an operation. Since his time, however, the womb has been punctured on many occasions through the vagina without a fatal result.

In cases of complete *atresia vaginae* the discharge of the retained menstrual fluid can be effected only by an operation per rectum. That this may be done effectually and safely, the case related by Mr. Brown proves satisfactorily. The subject of the operation was an unmarried female, 15 years old, well developed and of good constitution. An attempt had been made to form an artificial vagina, which failed in consequence of the extremely small amount of tissue to work upon. The operation per vaginam was followed, for a few days, by occasional attacks of pain, chiefly produced by the slow contraction of the uterus. Some degree of pain was due, also, to the efforts at natural menstruation. The appearance of healthy catamenia took place on the evening of the fourth day after the operation and during the next day. Pain also preceded the second menstruation for some days. There was not the slightest appearance of irritative fever. The general result of the operation is looked upon as extremely favourable.

On the *Uterine douche as a therapeutic agent*, with description of a new instrument for its application. By Dr. G. Hewitt. (pp. 27-30.)

The beneficial effects of the cold douche applied to such portions of the uterus as are accessible to its action from the vagina in several of the diseases of that organ has been long recognized. It is nevertheless true, that the uterine douche is but rarely employed by the profession at large. One reason why this is so, Dr. H. believes to be the want of a ready and efficacious mode of administering it. To employ the douche effectively an instrument is required at once portable, requiring no mechanical or other effort on the part of the patient, and admitting of the use of a large quantity of water. Such an instrument Dr. H. describes. It consists of a gum-elastic bag, capable of holding nearly a gallon of water, and of folding up when empty. From the bottom of this bag proceeds a long flexible tube. When expanded it is so maintained by a brass rod screwed in its centre. The action of this instrument depends on gravitation. All that is necessary is to place the bag a foot or two higher than the seat or couch occupied by the patient. The stopcock being opened a continuous flow of water, fast or slow, as is desired, takes place through the tube, the free end of which is inserted into the vagina.

Irrigation of the os and cervix uteri by means of this instrument, Dr. H. recommends as particularly advantageous, in cases of profuse menstruation with a lax condition of the uterine vessels, giving rise in many cases to prolapsus uteri; chronic leucorrhœa from the same cause; enlargement of the womb from defective involution after abortion or delivery—engorgement of the lips of the os uteri, associated with a hypertrophied condition of the mucous membranes, and excessive secretion of the mucous follicles of the cervix; in all cases, indeed, in which there is undue fulness of the uterine vessels, or defective tonicity of the muscular fibre generally.

On the *Thrombosis and embolia of lying-in women*. By Dr. Robert Barnes, of London. (pp. 30-53.)

By recent pathologists, many of the diseases incident to the puerperal female, are referred to certain abnormal conditions of the blood. Two of these diseases more especially form the subject of the communication before us. In the first of these the patient, at a period more or less approaching that of delivery, is seized with the faintness, intense pain in one or more of her limbs, followed by swelling, arrest of pulsation, loss of heat, gangrene, and it may be death. The morbid conditions antecedent to the sudden occurrence of such a series of severe and always dangerous phenomena, without an acquaintance with which no rational prophylaxis can be inaugurated, are yet to be developed through a carefully conducted course of clinical observations. In all the cases marked by the phenomena referred to, where a post-mortem examination has been made, blood clots have been found in the main arteries of the affected limbs.

Another class of cases are marked by sudden faintness, irregular action of the heart, distressed respiration, rapidly increasing collapse, and speedy death. In these cases it is found that the pulmonic circulation is almost exclusively concerned, and clot-obstructions are met with in the right heart and pulmonary arteries. Of the causes which give rise to this coagulation of the blood and the formation of embolia, we know little or nothing.

Dr. Barnes relates in detail a case belonging to the first class referred to, and then presents in tabular form the abstract of fifteen other cases he has met with on record. These cases offer several features of similitude as well as of apparent variation. Five were preceded by rheumatism, a disease which in the non-puerperal has been frequently found associated with embolia; in one of these cases the symptoms in the limb occurred six hours before labour. The earliest period of attack after labour was on the second day, the latest seven weeks. In eight cases indications of gangrene occurred within fourteen days. In twelve fatal cases, death ensued in from eleven days to three months. Recovery took place in two cases.

"It is clear," Dr. B. remarks, "from the history of these two cases, and from what is known of the history of aneurism and other forms of arterial obliteration, partial or complete, that a collateral circulation may, under favourable circumstances, be established; or that, if gangrene be not averted, the necrosed portion may be thrown off, life being preserved by the sacrifice of a part of the body. Indeed, it has been observed that the arteries are not always completely obstructed by the clot. A space sufficient to permit the passage of a limited stream of blood may remain open. In this circumstance, and the simultaneous extension of the collateral streams is a ground for the hope of recovery."

Death may take place in the primary stage during the commotion consequent upon the coagulation of the blood in the left heart, or so early after the transport or formation of coagula in the arteries as to anticipate the occurrence of mortification.

In two cases amputation was resorted to—in one successfully—a line of demarcation having been established.

In some of the cases there were, apparently, certain premonitory symptoms, whether of the formation of heart-clots or of their transmission into the arteries; such as dyspnoea, syncope, and irregular action of the heart. The earliest condition, recorded in the majority of cases, however, is pain in the limbs subsequently affected, and generally of the most excruciating kind. This has usually remitted when mortification appeared: pulsation ceases in the arterial trunks leading to the affected limb. In cases complicated with rheumatism signs of cardiac disease have been diagnosed.

In all the cases collected by Dr. B. one or more of the limbs were affected. In three the right arm and both legs; in one, the right arm and leg; in another, the left arm and both legs; in another, the left arm and leg; in another, the right leg; in two cases, the left leg.

The embolia may doubtless be carried to the brain, as well as to the liver, spleen, kidneys, heart, and eye.

"The cases," remarks Dr. B., "may be divided as to their post-mortem appearances, into two classes:—

"1. In those in which rheumatism was an antecedent condition there have been found the effects of endocarditis; the valves of the left side of the heart

have presented wart-like excrescences. In these cases it has been presumed that the accidents of local arterial obstruction were not always, or, at least, not exclusively, due to the sudden formation of fresh coagula in the heart, but chiefly to the detachment and washing away into the arterial system of portions of the valvular vegetations."

"2. In cases not complicated with rheumatism or previous disease of the heart, there is evidence to show that blood has suddenly clotted in the cavities of the heart, that the commencement of the mischief was in the heart, and that the local obstructions were the result of the detachment and washing away into the arteries of portions of the heart clot." "In cases where pain in a limb, or other local distress has been the first thing observed, the conclusion that the coagulation did not commence in the heart would be far from certain. At the same time analogy points out that the formation of obstructing coagula in the large arteries is not impossible."

Dr. B. proceeds next to the consideration of thrombosis or embolia of the pulmonic circulating system, which is often associated with a similar affection of the systemic arterial system. In the latter the disease, as we have seen, commences in the heart; there is primary central thrombosis and secondary peripheral embolia; while in the former, which is the most frequent, there is generally primary peripheral thrombosis, secondary cardiac implication, and tertiary embolia of the pulmonary arteries.

The abstract of fourteen cases found upon record of pulmonary thrombosis or embolia is presented in tabular form, and a probable case is detailed.

In six of these cases clots existed in the crural, iliac, hypogastric, or uterine veins; signs of phlebitis or uterine inflammation had preceded, often by long intervals, the symptoms of pulmonary distress. The first or peripheral symptoms were noted from twenty-four to seventy-two hours after labour; the secondary or pulmonic in from four to upwards of twenty after labour. Death occurred in from four to twenty-eight days after labour. In eight cases attended with great precordial distress, dyspnoea, and syncope, death was more or less sudden. In these cases it was generally found that the main branches and smaller ramifications of the pulmonary artery were clogged by coagula, while blood clots were present also in the right heart. When death occurred less promptly, symptoms of pneumonia had time to develop themselves, and in these it was found that the smaller ramifications of the pulmonary artery were obstructed.

"It seems," Dr. R. thinks, "reasonable to conclude that the sequence of events in pulmonic embolia is as follows:—

"1. There is dyscrasia of the blood immediately proceeding from the puerperal process, which is favourable to the production of clots in the uterine veins and veins of the lower extremities. Imperfect contraction of the uterus, the formation of putrilage in the uterine cavity from the admission of air, which acts upon the blood and serum squeezed out of the vessels, and the remains of adherent placenta or of decidua, are often the immediate antecedent conditions of peripheral thrombosis. This process is also favoured by the retardation of the circulation in the veins of the uterus and lower extremities, resulting from pressure."

"2. Portions of the peripheral thrombi, attended no doubt, in many cases by septic matter derived from the uterus, are carried to the right heart. If the solid matters be large enough, or the septic or ichorous matters be irritating enough to cause a violent perturbation of the heart's action, and to act chemically upon the blood mass, rapid coagulation of blood in the right cavities may ensue, followed by a similar process in the larger pulmonary arteries. In such cases sudden death occurs.

"3. In cases in which either minute portions of thrombi are taken up from the peripheral veins, or where the septic or ichorous matter is less virulent, no clot may form in the right heart, but minute emboli may be carried into the finer divisions of the pulmonary artery, causing lobular pneumonia, ending in slower death, or possibly in recovery. Pure thrombosis of the venous system—that is, uncomplicated with blood dyscrasia or fever—is not often fatal. It can only become dangerous when, from some accident, portions of peripheral clots

are carried to the heart." "As far as careful dissection can show, there seems good reason to conclude that obstruction of the pulmonary arteries may occasionally arise from *primary*, sudden or gradual, formation of clots in those vessels themselves."

"4. In many of these cases some mental emotion or sudden exertion has immediately preceded, and has seemed to be the exciting cause of the cardiac and pulmonic distress. It seems to me that this association may be explained by the temporary retardation of the blood current which is occasioned, and which offers a momentary facility for the chemical action of the septic or ichorous matter upon the blood. Possibly, also, sudden exertion may favour the detachment of portions of thrombi from the systemic veins. Whatever may be the explanation adopted, it is difficult to avoid the conclusion that in some of the cases the fatal catastrophe might not have occurred had the patient been kept in a condition of mental and bodily repose."

∴ In respect to treatment in cases of puerperal thrombosis and embolia, our main attention should be directed to prophylactic measures. Care should be taken to secure a healthy condition of the blood during pregnancy, by regular exercise in the open air, thorough cleanliness of the entire skin, a good generous diet, and occasional doses of aperient medicine. During labour care should be taken to insure the due and regular contraction of the womb, avoiding as much as possible the kneading or rather bruising process too often practised, and the irregular contraction apt to be produced by ergot. After delivery, lactation should be encouraged; nothing acts with equal efficacy in maintaining healthy contraction of the uterus, and promoting its regular involution; thus averting many puerperal disorders. The recumbent position should be enforced, all causes of mental or bodily disturbance guarded against, and a generous unirritating diet supplied.

When the disease is actually present, the same general treatment is to be continued, adding bark, stimuli, and the mineral acids, especially the nitro-hydrochloric. Dr. B. disapproves of the administration of ammonia. Amputation of the diseased limb cannot, he thinks, be safely resorted to, excepting in a very few exceptional cases—possibly, those of a post-rheumatic character.

The importance of the subject discussed by Dr. Barnes—the fulness and general excellence of his exposition of it, has induced us to present a very full analysis of his monograph on puerperal thrombosis and embolia, for which we shall receive the thanks of our readers, as but few of them can have the opportunity of consulting the paper itself.

Mr. I. Baker Brown reports the results of the *operation of ovariectomy* at the London Surgical Home, and the mode of operating (pp. 59–86). Nineteen cases are presented in tabular form, in thirteen of which the operation terminated favourably, and in six death ensued. To those who feel an interest in the subject of ovariectomy we recommend a careful perusal of the report and remarks of Dr. Brown, in connection with the discussion to which the reading of the report gave rise.

Dr. Robert Barnes presented a specimen of *an ovum in ovo* (pp. 87–89). It was an egg laid by a hen in South Wales, containing within it another perfect egg, enveloped in its own shell. The outer shell is of a dull chalky white colour, without gloss or polish, similar to the egg of the Dorking fowl; the shell of the inner egg is of a red tint, like that of the Cochins and partridge. Of these double eggs the same hen has laid, at irregular intervals, nine alike in every respect, even to the colour of the shells.

T. Spencer Wells, Esq., related a *case of ovariectomy*, with a reply to a statement respecting it, made by Mr. Baker Brown at a former meeting of the Society. The case and remarks of Mr. Wells should be read in connection with Mr. Brown's paper on ovariectomy, noticed above (pp. 39, 90).

Dr. J. Hall Davis describes a very unique case of *retention of the menses after difficult labour from complete occlusion of the os uteri* (pp. 91–96). Upwards of fifteen months after delivery the menstrual flux had not reappeared. The patient had had a thick yellowish discharge from the vagina; she suffered at times from pains in the abdomen; always felt uncomfortable, dull, and heavy; was soon fatigued; could not lie on her back; driving over uneven ground was

painful to her. Nearly three months subsequently, the uterus could be felt above the pubes, enlarged to the size of a four months' gravidity. A soft, somewhat elastic prominence of the uterus was perceived at the top of the vagina, with distinct fluctuation. The bowels having been regulated, the uterus was punctured with a canulated stilet at the most salient point of this prominence, in the axis of the organ, and to the depth of a quarter of an inch. The stilet was then withdrawn, and the canula passed into the uterus, when a portion of the retained catamenial fluid escaped, of the consistence of treacle, and unoffensive. To cause a freer discharge the aperture was slightly enlarged on each side with the hysterotome; six ounces of the fluid then came away, and more the next day. The aperture was maintained by leaving in it a No. 12 gum elastic catheter for two hours daily. The patient caught cold after the operation, and suffered from pain and other disagreeable symptoms; and after passing through a period of much danger, had regained her normal state, with regular menstruation, at the end of three months subsequent to the operation.

On the *nature and treatment of puerperal peritonitis*, by Joseph T. Mitchell (pp. 96-105). Among 4349 recorded cases of labour attended by Mr. Mitchell, there occurred 27 cases of well-marked puerperal peritonitis, of which in all but four the termination was favourable. Mr. M. had never encountered epidemic puerperal fever, and in no one case seen by him could he trace its origin to contagion. All the cases were treated at the patient's own residence. The treatment pursued by Mr. M. was bleeding to a greater or less extent, followed by large doses of opium; rest in the recumbent posture; with extensive counter-irritant applications (fomentations of hot water and turpentine, or sinapisms) over the entire surface of the abdomen.

The remarks of Dr. Routh upon the paper of Mr. M. made at the meeting when it was read, appear to us to be especially pertinent and correct; we therefore present them entire:—

"Dr. Routh said he should be sorry to learn that the profession had been influenced by Mr. M.'s paper to treat all cases of puerperal peritonitis by blood-letting. Casual cases met with in private practice were very different from those occurring in lying-in hospitals. There were, moreover, several varieties of the disease, the dynamic and adynamic, the contagious and non-contagious, etc. In his early career Dr. R. had seen a fearful epidemic in Vienna, where sometimes six hundred died a year. That fever was found to be non-contagious, and caused by direct inoculation of dead matter carried from the dead-house beneath the nails of the medical attendants. All kinds of treatment had occasionally succeeded—generally, however, had failed. In some examples, in which a particular kind of *facies* made its appearance, it could be surely foretold that death would occur, in spite of every treatment. In others, in which such *facies* was not observed, instances of recovery could be found under all kinds of treatment. The fatal cases gave indications of blood poison. Almost the first thing observed, even before the mother became seriously ill, was the sudden death of the infant with narcotic symptoms—poisoned by the breast milk. In these the effusion of false membranes and serum into the abdominal cavity was so rapid as to seem rather the result of decomposition of the blood than of inflammation. An acid state of the serum was to be noted in other examples. Bleeding in such cases was contra-indicated by all known physiological rules. As also in puerperal peritonitis, which prevailed at the same time with erysipelas. He believed that every epidemic, as well as every case, was to be studied by itself, and treated upon broad general principles, and not necessarily by bloodletting as a panacea."

Dr. Thomas Skinner presents some brief remarks on *anæsthesia in labour* (p. 116), the object of which is to show the safety with which chloroform can be employed to relieve the pains of parturition, and to exhibit a simple apparatus by which anæsthetic agents might be economically administered. In commenting upon Dr. S.'s remarks, Dr. G. Hewitt considered it important that the duration of labour in cases in which chloroform was given should be stated. He had found that chloroform sometimes exercised a most decided effect in putting a stop to the progress of labour, and that in cases where anæsthesia from other causes was most desirable.

A practical inquiry into the properties of nitrate of silver, with an account of a new instrument for its use in uterine disease. By Robert Ellis (pp. 116—128). After showing the caustic nature of the nitrate of silver, and the causes by which its action upon the living tissues as an escharotic, is limited; after enumerating, also, in brief terms the invaluable part it plays in the treatment of many affections of the uterus, whether simply as an alternative of diseased action or in the destruction of diseased tissue, and pointing out the unadaptedness of the lunar caustic of the shops, in consequence of its brittleness, for application as a decided escharotic to certain of the morbid conditions of the os uteri, Mr. Ellis proposes an improved method of casting the cylindrical pencils of nitrate of silver and a new instrument to facilitate its application. For an account of these we must refer to the paper itself.

Dr. Henry M. Mudge relates a case of large fibrous tumour impeding delivery. (pp. 129—133.) The tumour was attached to the external surface of the fundus uteri by a pedicle of an inch in length, which allowed it to drop into the pelvis at or before the commencement of labour. It was six and a half inches in diameter. Six small tumours were scattered over the external surface of the uterus. The large tumour consisted of fibro-cellular tissue of a dusky white colour, with irregular channels, containing a straw-coloured fluid; the whole inclosed in a capsule formed of uterine substance and fibres. The latter were so intimately blended and interlaced with the white tendinous fibres of the interior as to render any attempt at enucleation of very doubtful success, while the large vessels which permeated the pedicle would have rendered excision very dangerous. The tumour was reduced in size by first introducing a trocar in it, and subsequently enlarging the orifice thus made; it was then pushed above the brim of the pelvis, and by the aid of a blunt hook the child, of which the breech presented, was brought down. When born it had some faint signs of life, which soon became extinct. In the latter part of the day after delivery peritonitis set in, which, in seventy-two hours, terminated fatally.

The next paper is entitled "*twin (?) abortion.*" (pp. 133, 134.) Mr. J. C. Langmore exhibited two specimens. The one a fœtus of perhaps some three or four months, which was flattened, and had been dead some time before it was expelled, at the fourth catamenial period, after very slight pain. The placenta was removed three hours afterwards. The hand being introduced to remove clots brought away a second and perfect ovum of about four weeks; its membranes were healthy, and the embryo as seen through them was fresh and vascular. The circumstances of this case seemed to point to the fact of superfœtation having occurred. The specimens were referred for examination to Drs. Harley and Turner, who, in their report, presented at the next meeting of the society, gave it as their opinion that the production of the second ovum of four weeks was in all probability from superfœtation. (pp. 165—169.)

Dr. J. H. Aveling presented his *polypryte*; a new instrument for crushing the necks of uterine polypi. (p. 135.) The instrument consists of a long hook, a slide, and a screw. The hook is to be first passed over the neck of the polypus; the slide is next to be pushed up as far as it can be made to go by the hand, and then by means of the screw the operation is completed by forcing the blunt blade of the slide into the concavity of the hook and through the neck of the polypus.

Dr. H. Cooper Rose presented a new description of nipple shield, and described his plan of treating sore nipples. (pp. 135—138.) The body of the shield is of glass, bell shaped, with a pyramidal hollow projection proceeding from its upper part and communicating with its cavity by a contracted perforated stem. Over the latter cone-shaped projection is to be simply tied a calf's teat, a piece of wash leather, or an India-rubber nipple, which when not used should be kept immersed in clean cold water. The advantages of this shield is that the cylindrical portion is sufficiently long to insure a space or vacuum between the end of the mother's nipple when fully drawn out, and the end of the shield. When this part is too short the nipple is drawn up to the top entirely filling it, the lactiferous ducts being, in consequence, blocked against the hard substance of the instrument. The diameter is, also, sufficiently large to prevent strangulation of the nipple. The shield is smooth and unyielding, to avoid friction, and

transparent, allowing the flow of milk to be observed and the position of the nipple ascertained. The substance used for the mouth-piece should resemble as much as possible the parent's nipple, and so arranged that it cannot collapse and allow the child to suck in air.

The plan of Dr. Rose is to direct the use of this shield for the first week or two, or longer if there be a tendency to tender nipples, at the same time he applies to the latter, after each time the child is nursed, a saturated alcoholic solution of gum benzoin and glycerine in equal proportions.

Mr. Henry Grace describes a curious case of *double uterus with simultaneous gestation*, and Dr. Richard Hodges one of *presentation of the right arm and shoulder, delivery by the natural powers, or spontaneous evolution*. (pp. 138—140.)

The history of four additional cases of *ovariotomy* is given by Dr. W. Tyler Smith. The disease of the ovaries was in all cases polycystic. In two of the cases both ovaries were affected, in the other two only one, the left ovary. The results were, in two cases death, in two recovery. (pp. 141—144.)

An interesting case is related by Dr. Wm. Newman, of an *enormous development of hydatids in the omentum, etc., simulating an ovarian tumour*. (pp. 169—173.) The case was one in which an absolutely correct diagnosis was next to impossible during life. The area and character of dulness on percussion, the external appearance of the abdomen, its firm, undulated character, unaltered by the supine position, the resistance to pressure and the fluctuation presented the same characters precisely as they do in multilocular ovarian disease.

A case in which *air was expelled from the vagina* is related by Dr. George Harley. (pp. 173, 174.) The expulsion of the air was attended with a loud noise. Although odourless, the discharge caused great personal discomfort. It had existed about eighteen months, commencing at a catamenial period, and had recurred at each period to an increased extent. At the date of report there were several expulsions in the course of a few minutes. The patient is married, and the mother of three children. No communication existed between the vagina and rectum. A full-sized male catheter was introduced into the uterus with a long India-rubber tube leading from it and having a stopcock at its lower end, which latter being placed in a tumbler of water, it was found that no air escaped; but when the catheter was introduced no further than the vagina an instantaneous discharge of air took place, and soon afterwards it was found that the water from the tumbler was drawn up through the tube into the vagina. It became evident, therefore, that the vagina in this case drew in the air of the atmosphere and again expelled it by a spasmodic action. In this result the abdominal muscles were found materially to assist. Although the patient could not commence the action, yet, a few minutes after it had begun, she could continue it at will. The uterus was completely retroverted. The posterior lip of the os ulcerated. The patient's general health was not good, she having a careworn and anæmic look. Had suffered from dysentery in India.

The uterus being replaced, and a course of strong nervine tonics entered upon, with astringent vaginal injections, the spasmodic action of the vagina was completely arrested by the end of two or three weeks.

A case of *imperforate rectum, with unsuccessful attempt at relief by operation*, is related by Dr. Wm. T. Fox. (pp. 195—197.) The patient was a male child four days old. Had a small but normal looking anus into which a probe could be introduced, and one-eighth of an inch beyond. A trocar was passed into the anus and carried in the direction of the rectum for about an inch and a half. No good resulted, and the patient soon after died. Upon dissection it was found that the rectum terminated in a cul-de-sac about an inch and a half from the anus, with which it was connected by cellular tissue.

A very interesting case of *rupture of the vagina during labour* is related by Dr. Jno. H. Bell. (pp. 197—202.) The child had escaped into the abdomen, where it remained three and a half hours before it was delivered by turning. The body was born promptly and without difficulty, but before the head came away considerable time and force were required. The placenta was readily delivered by the hand, but whether from the cavity of the uterus or abdomen could

not be ascertained. No untoward or very severe symptoms occurred, and in less than three months from the accident the patient was entirely well.

A very singular case of *unsuspected pregnancy* is related by Dr. Jno. Shortt. (pp. 202—204.) It was the patient's third pregnancy; during the greater part of which she had been treated for obstinate costiveness, and supposed displacement and inflammation of the womb. In the latter period of gestation the intumescence of the abdomen was mistaken for ovarian disease. When the membranes became accidentally ruptured, two days before delivery, it was supposed that an ovarian cyst had given way. When the pains of labour set in a surgeon was called, who pronounced the case to be one of rupture of an ovarian cyst into the abdominal cavity. An opiate draught, etc., was ordered, and the patient placed in a warm bath, when, to the surprise of all parties, a living child escaped into the bath, and would have been drowned but for the presence of mind of an assistant. The child was a boy, at maturity, well proportioned, of average size, but of rather lanky appearance and pigeon-breasted.

The patient, although twice a mother before, appears to have been entirely ignorant throughout of her pregnancy; all her feelings she attributed to disease. The birth of a son was, as she declared, "the greatest surprise she ever experienced." Another remarkable feature in this case was that for almost two-thirds of the period of gestation the speculum, caustic, &c., had been applied to the os uteri, and the most drastic purgatives administered without any injurious effects.

Dr. Thomas H. Tanner comments on *the use of medicated pessaries in the treatment of uterine disease*. (pp. 205—208.) "There are few uterine diseases," he remarks, "in which the use of medicated pessaries may not advantageously form a part of the treatment. But they are more especially valuable in acute and chronic inflammation of the cervix uteri, in internal metritis, with exfoliation of the lining membrane of the uterus, in slight prolapsus or procidentia, in cancer, in all varieties of ovaritis, as well as in many affections of the female bladder. By means of them the diseased parts may be kept constantly bathed in such drugs as mercury, iodine, lead, zinc, belladonna, opium, conium, &c. They are not only most efficacious in relieving pain, but they also shield the diseased and irritable surface from contact with the vaginal walls. Owing to this latter property they are of great utility in healing excoriations about the labia uteri, though, of course, part of the benefit derived from their use in these cases must be attributed to the absorption of the materials composing them. By their employment, moreover, the necessity for frequent examination of the morbid structures is greatly diminished.

Dr. Tanner presents some six formulæ for medicated pessaries adapted to different forms of uterine disease.

A case of *sudden and unconscious delivery* is reported by Dr. Jno. Shortt. (p. 210.) The patient was a Hindoo of caste. Whilst walking with two companions, carrying, all three, loaded baskets on their heads, she suddenly, without any preceding pain or other premonition, felt her child slip between her thighs to the ground; the after-birth came away soon after. The patient was in good health, twenty-eight years old, and the mother of two living children. She knew herself to be pregnant, but did not expect to be confined for some days.

A case of *obstructed labour from the presence of the hymen* in a patient thirty-one years of age is related by Dr. S. Palmer. (pp. 211, 212.) The hymen was of the type of what may be termed fenestrated. That is, having a central band extending from beneath the meatus urinarius to the fourchette, bounded on each side by a perforation or opening. On the left side the margin of the central band was smooth and rounded, while on the right it was fringed. The central band being divided with a pair of scissors, almost immediately after the child's head passed into the world. The scalp was greatly tumefied, and there was a deep sulcus where the band had pressed which did not disappear for ten days.

Case of *acephalo-cyclopean monstrosity*. By Mr. R. Hardey. (pp. 213—21.) The most remarkable features in the case of this monster, was the entire absence of a head, while the rounded and somewhat protuberant termination of the upper portion of the chest presented a face of which the cheeks and mouth were directed upwards. The face was of full size, mouth unusually round, with

a protruding tongue very thick and firm. The cheeks were large, protuberant, and livid—no doubt from long continued pressure during labour. Chin scarcely discernible, but situated at the usual distance from the mouth. Nose entirely wanting. From the centre of the upper lip there ran posteriorly a sulcus, separating the cheeks, and terminating at the central, pointed margin of a rounded cavity, measuring $1\frac{1}{2}$ inch from before backwards, and about $1\frac{1}{2}$ inch across. This cavity, surrounded by a ciliary margin and a few cilia, contained a large globe, possessing *two pupils*, one on each side of the mesial line. The eye itself was protruded forward. The monster was born dead.

Mr. Hardy remarks that his experience, founded upon nearly 6500 cases of labour attended by him during the last forty years, "is in direct opposition to the prevalent opinion that monstrosity in the *fœtus* is traceable, in a large number of cases, to strong impressions made on the mother's mind during early gestation"—the child when born being marked in the way anticipated by the mother.

The volume contains the history of another *case of monstrosity*, described by Dr. A. Meadows. (pp. 255–59.) The child in this case, which appeared to have arrived at the seventh month, instead of possessing the usual organs of locomotion had at the lower extremity of the body a pointed caudal appendage measuring about $5\frac{1}{2}$ inches from the extremity of the spine.

Dr. A. Hall relates a case of *puerperal convulsions complicated with mania*. (pp. 222–23.) In this case, after apparent recovery, death suddenly ensued.

Dr. J. Braxton Hicks relates five cases of *vaginal closure*. (pp. 228–42.) The first was a case of entire absence of the vagina (*atresia*) with retained menses, in a girl, 18 years of age: the uterus was punctured through the rectum. The operation was successful: but as there was no menstrual discharge for the ensuing seven months, and for the relief of the intense pain under which the patient suffered, the operation was repeated; after which she menstruated regularly per rectum without pain or inconvenience.

The second case was that of a married woman, 28 years of age. There was complete *atresia of the vagina*. The formation of an artificial vagina was attempted. The patient refused to submit to the completion of the operation.

The third case was one of *excessive dysmenorrhœa from almost complete occlusion of the vagina*, occurring in a married woman, 25 years of age. The occlusion was the result of cicatrices, which were carefully divided by the bistoury, and subsequently a large bougie was introduced into the vagina and constantly worn by the patient. The operation was completely and permanently successful.

The fourth case was one of *almost entire obliteration of the middle third of the vagina*, with conversion of the upper third into a large sac distended with pus. The patient was in the seventh month of her second pregnancy, which occurred seven months after her previous delivery. Pains, at intervals, had set in for three or four days. The vagina was opened by the knife, and a cavity penetrated, from which were discharged some four or five ounces of pus. The next day but one she gave birth to a dead child. The recovery was complete with patulous vagina, in which a bougie had been constantly worn.

In the fifth case the *middle third of the vagina was contracted to the size of a quill*, in a woman in labour with her second child. The cicatrices in the vagina were divided by the knife. The child being dead, its head, which was firmly impacted in the brim, was perforated, and with much trouble delivered. Recovery was speedy, and two years subsequently the patient was delivered of a dead child, without any trouble.

Dr. Thos. H. Tanner relates a case in which there occurred the somewhat unusual *complication of multiple medullary cancer with pregnancy*. (pp. 243–50.) The patient was about five months advanced in her third pregnancy. Premature delivery was determined upon to increase the woman's comfort, and from the fact that, as the vagina was already nearly blocked up with a cancerous growth, the birth of the child at the full time would be impossible. The *fœtus* could only be removed piecemeal after being broken up. At the end of some twenty-six days after the operation, the patient died from extreme exhaustion.

The history of this case confirms the general opinion that the existence of cancer does not interfere with a woman's fertility.

- Case of *retention of the catamenia* for more than two years, in a married woman; by W. Chapman. (pp. 251-55.) For upwards of two years after having undergone a second operation for vesico-vaginal fistula the patient had not menstruated. At the end of that time she was able to superintend her domestic affairs, to walk out, attend church, and to a casual observer, presented the aspect of health. She complained of great irritability of bladder and stomach, frequent vomiting, and pain in the lower part of back. On examination of the abdomen externally, the existence of a large tumour, resembling the uterus at about the sixth month of pregnancy, was revealed. A vaginal examination showed the cervix uteri to be lost in a general enlargement of the uterus, but no os could be discovered, a thin membrane being detected by the finger in its stead. The speculum showed that the os was hermetically sealed. Soon after the cessation of her menses the patient had suffered more or less distress, which was augmented to severe pain and spasms at every monthly period; on which occasion she had occasionally a copious whitish inoffensive discharge. The diagnosis was retention of catamenia from a closure of the uterine orifice. On this being re-established, by scratching through the membrane existing where its site should have been, until an opening was made large enough to admit the tip of the finger, there was immediately a copious flow of some ten or twelve ounces of a thick fluid of a dark claret colour, and free from all unpleasant odour. Three days after the operation, after improper exertion and exposure, the patient was attacked with severe pain of the abdomen, tympanitis, sickness, small and rapid pulse. A full dose of opium and calomel speedily relieved her, and soon after her bowels were freely opened. In the ensuing week, the discharge from the uterus having become thin and offensive, a full sized elastic male catheter was introduced, through which the uterus was washed out with tepid water, almost daily.

For ten days after the operation the patient seemed to be doing very well. On the eleventh it was ascertained that she had been very sick during the preceding night; could retain no nourishment: her countenance was pale and shrunk, her hands cold and damp. No pulse could be felt at the wrist. Brandy and water was administered. She recognized, and spoke to her friends around her. She continued to sink rapidly, and in a few hours was a corpse. She remained sensible to the last. A post-mortem examination could not be obtained.

In the concluding communication of these transactions, Dr. W. Tilbury Fox discusses the question as to the *influence of the mother's health in the production of rickets* (pp. 260-75).

From the facts adduced by Dr. Fox in the communication before us, there can be little doubt that rickets may be produced in the infant by any marked deterioration of the mother's milk when this is made its sole nourishment. The same would seem to prove also that profuse or regular menstrual discharges taking place during lactation is a prominent cause of an impaired lacteal secretion. But we cannot go so far as Dr. F., and pronounce the occurrence of menstruation during lactation to be the only cause of deterioration in the milk of the mother or nurse, nor do we believe that the facts adduced by him warrant such a conclusion. Nor can we agree with him, as he would seem to teach, that the impaired quality of the breast-milk upon which the sucking infant is exclusively nourished, is the chief if not the only cause of rickets. It is no doubt, in many cases, a very powerful co-operating cause, but facts which cannot be gainsaid seem to prove, incontestably, that among the causes of the rachitic condition, are exposure to a stagnant, impure, raw, damp and cloudy atmosphere, badly ventilated, damp, dark, and unclean dwellings, defective clothing, personal uncleanliness, long-continued quietude in the recumbent posture, want of sufficient and appropriate food, and intemperate and other vicious habits on the part of the mother.

D. F. C.